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Back to Center Stage: ACA Decision Gives New Significance to Medicaid Family Planning Expansions

By Rachel Benson Gold

If fully implemented, the Affordable Care Act (ACA), would give nearly everyone in the nation a pathway to insurance coverage—at least on paper. But the experience in Massachusetts, a state that is several years farther down the road to health care reform than the country as a whole, shows that coverage is still not as seamless as intended. Moreover, the Supreme Court's decision to make the expansion of full-benefit Medicaid optional, rather than mandatory, for states may well mean that many states will fail to take up that option. These realities mean that the Medicaid family planning expansions now in place in 26 states will continue to have an important role to play and that, in some states, these programs may be the only coverage for which some low-income women will be eligible. Nonetheless, 18 of these programs—those that are operating under waivers from the federal Centers for Medicare and Medicaid Services (CMS)—are in danger of being terminated when full implementation of health care reform begins in 2014.

Over the last two decades, 26 states have broadened eligibility for family planning services to individuals with an income well above the states' regular Medicaid eligibility ceiling; five others have adopted more limited expansions.[1] Most of the 26 states have set the ceiling for family planning at or near 200% of the federal poverty level. (The poverty level for a family of three in 2012 is $19,090.[2]) Individuals enrolled in programs in these states are covered for a package of care that includes the full range of contraceptive methods, as well as associated examinations and laboratory tests; in some states, it also includes other closely related care, such as treatment for STIs diagnosed in the course of a family planning visit.

These programs serve nearly three million clients a year, and according to numerous state program evaluations and national analyses, they have increased women's contraceptive use, expanded their use of more effective methods and improved their continuity of use—all important factors in reducing high rates of unintended pregnancy among low-income women.[3] Such an improvement in contraceptive use has translated into measurable declines in unplanned pregnancy and teen pregnancy, and in the births, abortions and miscarriages that would otherwise have resulted. In addition, it has helped women to plan and space their pregnancies, which in turn has positive implications for the health of pregnant women and newborns, as well as for the economic and social well-being of families.

At first glance, it would appear that the ACA would render these family planning–specific expansions far less important than they had been in the past. As originally envisioned, the ACA drew a clear line at 138% of the federal poverty line: Individuals below that line would be eligible for full-benefit Medicaid coverage, and those above it would have private coverage, with subsidies available for those needing help affording it. However, the six-year experiment with health care reform in Massachusetts shows that the goal of providing universal health insurance coverage remains elusive.

Addressing Persistent Gaps

With much fanfare, then-Governor Mitt Romney signed a sweeping health care reform bill into law in Massachusetts in 2006. Like its federal progeny, the measure required residents to obtain coverage. It also extended Medicaid eligibility to individuals with an income up to 133% of poverty and provided subsidies to assist those needing help purchasing private coverage.

Since then, coverage in Massachusetts has increased substantially and access to care has also improved. In 2010, 2% of all state residents were uninsured, compared with over 6% in 2006.[4] Moreover, more adult women in Massachusetts now than before the law's implementation report having a usual source of medical care and that they made a medical visit in the last year.[5]

Unfortunately, this remarkable progress has not fully translated into women always having coverage for their family planning needs. Despite the implementation of statewide health care reform, Massachusetts paid for three in 10 clients receiving services at family planning centers in the state in 2011 (accounting for 31,000 of the 102,000 clinical clients served by family planning centers that year); these individuals either had no coverage or had coverage they could not use for their care. In the absence of the state having a Medicaid family planning expansion under which the cost would be shared by the federal and state governments, Massachusetts uses its own funds to reimburse providers for this care.[6]

There are likely several reasons behind these somewhat shocking statistics. Many of the clients lacking insurance were likely not covered because of their immigration status. Some clients might be enrolled in high-deductible plans that make coverage essentially meaningless when a woman needs it for family planning, an issue that hopefully will be largely addressed as the ACA's nationwide ban on cost-sharing for contraceptive services rolls out. And some others may have made the calculation that paying the penalty for not having coverage was a more affordable option than purchasing insurance, or had that decision made for them by another family member, such as a parent or a spouse.

But for others, the explanation is likely more nuanced. Even though, on paper, it does not seem that any identifiable group of women—aside from many immigrants—is left without a pathway to coverage, it appears that there is a potentially sizable group of women for whom regular insurance processes fail. In Massachusetts, their care—for the moment at least—is paid for by the health department's program. In other states that lack this sort of categorical funding stream, the gap could be filled by a Medicaid family planning expansion.

Gaps in coverage. Even though only 2% of residents were uninsured at the time of the state's last survey, nearly 6% reported that they had been uninsured at some point during the past year.[7] Moreover, lapses in coverage were more common among young and low-income residents as well as those who were single with no children. For example, 11% of individuals 19–25-years-old and 12% of those with an income under 300% of poverty had a gap in coverage during the last year. This is particularly concerning because these are individuals at particularly high risk of unintended pregnancy.[8]

These coverage gaps appear to often coincide with changes in life circumstances. For example, a study by Ibis Reproductive Health and the Family Planning Program of the Massachusetts Department of Public Health found that women aged 19–24 who are transitioning into adulthood have difficulty obtaining coverage if they are not remaining on their parents' policy, as do women whose primary residence changes frequently.[9] The study also noted that coverage is likely to lapse during other transitions, such as when a woman gets or loses a job, becomes pregnant, gets married, becomes divorced or separated, starts or finishes college, or establishes a first residence independent of her parents. These findings are particularly distressing because these sorts of major life changes have long been associated with gaps in contraceptive use.[10] As further evidence of the connection to an increased risk of unintended pregnancy, a new study by the Guttmacher Institute found that more than half of women obtaining an abortion have experienced at least one disruptive life event—such as becom-

ing unemployed, getting separated or divorced, falling behind on rent or mortgage, or changing address multiple times—during the past year.[11]

Although Medicaid family planning expansions cannot address lapses in full-benefit coverage, they could be an important partial step to filling these gaps, at least when it comes to women's family planning needs. Point-of-service enrollment, which is an innovative feature of some expansion programs, could bring coverage for this limited package of care to clients in the course of a family planning visit. Similarly, presumptive eligibility could provide immediate, albeit temporary, coverage for women seeking to meet a time-sensitive health care need. Once these immediate needs are met, and the woman is again in the insurance system, her case could be turned over to patient navigators who could work to reconnect her with the longer-term, full-benefit coverage she—and potentially her family—needs.

Eligible but not covered. Medicaid enrollment has always lagged behind eligibility, a long-standing fact that leads experts to expect that, even if implemented nationally, the Medicaid expansions under the ACA would likely reach only 60–80% of those eligible.[12] And on the basis of this fact, it is likely that some of the women who come to family planning centers in Massachusetts without coverage are actually eligible for Medicaid.

Although there may be many reasons behind this phenomenon, for some people, that enrollment in the program is based on the family unit may be an issue: The individual seeking family planning services may not be the person in the family empowered to seek enrollment. Here again, the Medicaid family planning expansions could help fill this important void by allowing women to enroll as an individual rather than as a part of a family unit. Moreover, at the same time that they enable these individuals to meet their immediate need for care, the family planning expansions may also start them and their families down a pathway toward full-benefit coverage, by at least initiating a connection to the health insurance system, including to patient navigators that could help facilitate the process.

Unusable coverage. Some women—especially those needing confidential care—may have coverage that they feel they cannot use to meet their reproductive health care needs. This fear stems from the fact that when anyone insured as a dependent on someone else's policy—whether through a parent or even a spouse—accesses care, insurers generally send an "explanation of benefits" form to the policyholder. By identifying where care is obtained, this standard insurance practice effectively precludes confidentiality for dependents.[13] This might especially be a problem for teenagers seeking contraceptive or STI services, as well as for some adult women, specifically those who may be at risk of intimate partner violence or in other difficult family circumstances.

By extending the option of dependent coverage to young adults up to age 26, health care reform might have inadvertently exacerbated this long-standing problem, because all of the more than three million young adults already covered through this provision are insured as dependents on their parents' policies.[14] Interestingly, in Massachusetts, this issue seems to be particularly acute for young adults accessing STI services, including testing for HIV, even more so than for those seeking contraceptive services.[15] Here again, the Medicaid family planning expansion may help fill this gap, by including a so-called "good cause exception" that allows individuals who have insurance coverage they feel unable to use for sensitive services to enroll as a way to access confidential care.

Filling the Court-Created Void

Even as the Medicaid family planning expansions can fill gaps likely to linger after the implementation of health care reform, the vagaries of the Supreme Court's decision on the ACA opened a potentially even larger void that Medicaid family planning expansions may be uniquely positioned to help fill. By making the expansion of full-benefit Medicaid optional for states, the Court's decision could leave millions of Americans whose income is above their state's current Medicaid ceilings without access to full-benefit Medicaid coverage. The eligibility ceiling for parents is below 60% of poverty in half the states, and childless adults are ineligible entirely in 42 states.[16]

Many of these individuals would likely also be ineligible for subsidies to help them defray the cost of private coverage. Because the framers of the statute had envisioned that they could all enroll in Medicaid, individuals with an income below poverty are not eligible for subsidies. (The only exception under the statute is for recent legal immigrants, who were given access to subsidies at a lower income level because they are barred from Medicaid for their first five years of legal residence.) This "donut hole" would trap millions who would find themselves too "rich" for Medicaid, but still ineligible for subsidies. The Urban Institute estimates that 3.4 million women aged 19–44 could fall into this void.[17]

This Supreme Court–created donut hole moves the Medicaid family planning expansions back to center stage. In states that choose not to take up the expansion of full-benefit Medicaid but that have a more limited family planning expansion, these programs would be the only subsidized coverage available to individuals between the state's regular Medicaid eligibility ceiling and 100% of poverty, making them a lifeline for low-income residents.

Of the 27 states that joined the suit against the ACA—and that are therefore considered among the least likely to adopt the expansion of the full program—14 have family planning expansions already in place (see "Affordable Care Act Survives Supreme Court Test, but Medicaid Expansion Placed in Peril," Summer 2012). None of these 14 states offer full-benefit Medicaid coverage to adults who are not already parents.[16] And although some have relatively generous ceilings for parents, eight set their ceilings below 50% of poverty. For example, in Alabama and Indiana, which both have regular Medicaid ceilings at about 24% of poverty, the states' family planning expansion could be the only subsidized coverage available for individuals without children or for someone in a family of three with an income as low as $4,600 a year.

Critical Programs at Risk

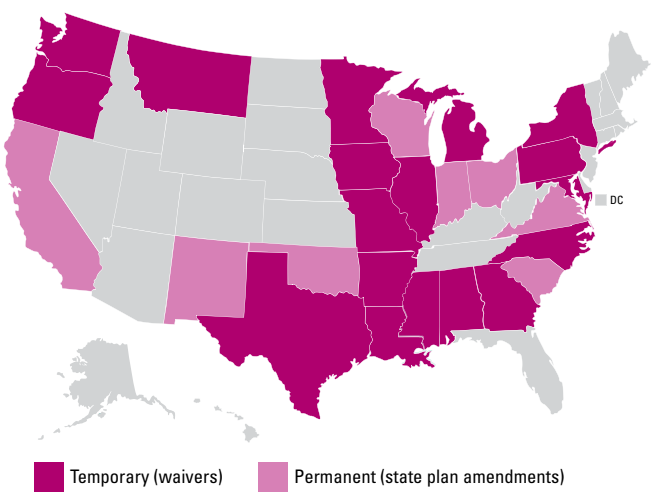
The experience in Massachusetts—especially the fact that the state pays for more than one-third of all family planning center visits, because women are either uninsured or have care they cannot use to meet their reproductive health needs—clearly indicates that Medicaid family planning expansions will have a vital role to play nationwide even after health care reform is implemented. On top of that, the Supreme Court's decision that made the expansion of full-benefit Medicaid a state option created a donut hole that the family planning expansions are uniquely positioned to fill, offering perhaps the only pathway to coverage for some poor residents in many states. Nonetheless, the future of most of these critically important programs is in jeopardy.

Eighteen of the family planning expansions operate under a waiver given states by CMS; these waivers authorize programs only for a specific period of time (see map).[1] (The remaining eight family planning expansions operate under a newer authority, known as a state plan amendment, under which programs can operate indefinitely.) Presumably based on an assumption that these programs will no longer be needed once the ACA is fully implemented in 2014, CMS has been moving to terminate family planning waivers as of December 31, 2013.

Although that date is still more than a year away, it is vital that CMS move now to reverse this

TICKING CLOCK

Eighteen of the 26 broad-based Medicaid family planning expansions are operating under a temporary authority that could terminate at the end of December 2013.



Source: reference 1.

decision and extend these programs beyond that point. Failure to do so will set in motion a process that, once begun, will be hard to reverse. For example, most of these waiver programs now enroll individuals for 12 months of coverage. If a program is to terminate at the end of 2013, systems will need to be reprogrammed so they only generate enrollment cards up until that point; making those system changes can take months, and so may already be in progress in some states. Moreover, states will soon need to begin to inform both providers and enrollees of the programs' impending termination.

Clearly, these family planning programs will still be needed in 2014, and beyond. To enable states to meet those needs in as seamless a way as possible, CMS would be well served to move now to extend these programs, so they can be the safety net that enrollees need and that they are uniquely positioned to be. **www.guttmacher.org**

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